Acknowledgement and Authorization of Insurance Deductions

ACTIVE

I, _____, hereby certify under penalty of perjury that the information provided in this application for employee Medical benefits, including social security numbers, addresses, spouse and/or dependent child(ren) information, is true and correct. I further acknowledge that I understand that providing false information may subject me to a denial of employee benefits. I authorize the release of information to my employer, the City of Memphis and insurance carriers. In addition:

- I authorize my employer to reduce my salary by Pre-Tax or After-Tax deductions, either prospectively or retroactively, for my elected benefits.
- I agree that it is my responsibility to check my earnings statement each month to verify my current benefit enrollments and deductions are correct and to alert the Health, Wellness and Benefits office of the City immediately of any errors. Further, I understand that the City may not be able to remedy problems identified beyond 30 days.
- I understand that my benefits can only be changed during the designated annual Open Enrollment period or by written notification to the Health, Wellness and Benefits office within 60 days of a qualified life event.
- I understand it is my responsiblitiy to notify the Health, Wellness and Benefits office within 60 days to remove my ex-spouse from all benefit plans if I divorce or become legally separated.
- I understand that while I am on an unpaid leave of absence or any unpaid status, I am responsible for paying my benefits premiums. Failure to pay premiums timely may result in cancellation of my benefits and reimbursement of any claims paid to my provider(s) for healthcare etc.

My signature below indicates that I have read and understand the above:

_____ _____

Signature Date

_____

Printed Name

Health, Wellness & Benefits Office Use Only:

Employee enrollment Date:	Termination Date:	Employment Status:	Received By Date:	Entered By/Date: